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Psychosomatic Leukorrhea

Report of a Case

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VAGINAL LEUKORRHEA is a common gynecologic complaint. Common causes include infections of the vaginal tract, such as those caused by *Tr. vaginalis*, *Monilia albicans*, and *N. gonorrhea*, and inflammations of the cervical and endocervical areas. Neoplasms must be considered. Psychic causes, however, do not seem to be commonly listed among etiologic factors. It is well known that erotic stimulation can cause leukorrhea of at least a temporary nature, and it follows that the psyche may cause this condition. Following is a report of a case of persistent leukorrhea, caused by psychic conflict, which almost escaped detection because of several complicating factors.

REPORT OF A CASE

The patient, a 28-year-old, white, married woman was first observed for a routine prenatal examination. She had been married for about two years and the pregnancy was her first. She said that another physician had told her she had a "contracted pelvis" and that she might have to undergo uterine section for delivery. She added that the physician also had treated her for a troublesome vaginal discharge and that nothing he prescribed had given relief. The discharge was described as thick, white, non-irritating, not foul, but copious enough to necessitate wearing a pad.

She said that she and her husband were compatible in all respects and that intercourse was satisfactory. Throughout the history, examination and subsequent visits, the patient always maintained an air of sophistication coupled with complete candor in discussing matters of sex.

The patient was in about the seventh month of gestation. The pelvic outlet was moderately narrowed in the transverse diameter. The vaginal vault contained an excessive amount of mucus, but no cause for this was found except the pregnancy. A hanging drop preparation was negative for *Tr. vaginalis*. No pathogenic organisms were seen on examination of smears of material from the urethra.

The patient was advised that uterine section probably would not be necessary, since the fetus was small, and that the vaginal discharge probably was physiologic, even though it was more copious than usual. She was instructed, however, to use Floraquin® suppositories nightly in an effort to reduce the secretions.

At the next visit two weeks later the patient was distressed because the discharge had not lessened. She said that coitus had been rather painful for her lately, and that the vagina seemed to be rather "small," with actual friction causing the pain. Her husband, she added, was very considerate and always took time enough to stimulate her prior to the conjugal act. Instructions were given the patient to refrain from further contact insofar as intercourse, douches, etc., were concerned, since the time of delivery was so near. Just before time for the patient's next visit, the patient's husband telephoned that his wife was having considerable gastric distress. Upon examination it was found that the distress was in fact labor. The patient was admitted to hospital and, with midline episiotomy, was quickly delivered of a viable male baby weighing 5 pounds 6 ounces and estimated to be a month short of term. Mother and baby did well during the hospital course and the puerperium was uneventful. At examination six weeks after delivery, involution seemed complete, with good healing at the site of episiotomy. Some Nabothian cysts of the cervix were noted but they were not treated at the time. The patient continued to complain of leukorrhea and occasional dyspareunia but no physical cause could be found. On a subsequent visit cautery was used to treat the cysts, and the endocervix was cauterized by the bi-active coagulation electrode technique on three occasions. A hemorrhage occurred from the site of one of the cauterized cysts about ten days later and additional cauterization was necessary to stop it. Normal menstruation was soon resumed but the patient still complained of leukorrhea and moderate dyspareunia. Acid douches and antiseptic suppositories did not help, nor did the use of lubricating jelly.

With the patient's consent, the husband was interviewed. He was pleasant and intelligent but, concerned over his wife's condition, he considered sending her to a medical center for further study and treatment. Encouraged to speak of his wife and her background, he said that she had begun to have leukorrhea the day they were married, even though, because of moving and other circumstances, they had not had intercourse until a week later. He had never felt that his wife had enjoyed the act, even though her libido seemed adequate; he doubted that she had had more than a few orgasms during the course of their marriage. She was of a typical middle class family of "working people," never in want and never in luxury. The parents were good enough to the

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daughter, but they did not share intimacies or discuss matters relating to sex, nor did they encourage the girl to develop normal relationships with boys. There were no brothers. Dates were infrequent; she had not gone out with men at all until after graduation from high school. She had been frightened by some of the advances that were made to her by various men, and her husband felt that she was very naive regarding men and the actual mechanics of sex.

The husband was asked to have a thorough talk with his wife and to send her back for additional talks with the author. Subsequently all the facts related by the husband were confirmed. Asked why she had not spoken of these matters before, she merely said that she had not considered the facts important enough to tell. In the course of a few talks, she gained insight into her problem—that she had actually feared sex and the sex act, and that leukorrhea was actually a defense against it. Care was taken not to offer this explanation to the patient until she herself suggested it. Leukorrhea thereupon dramatically ceased, as did dyspareunia.

COMMENT

At the time the present report was being written, the author conferred with various physicians regarding psychosomatic leukorrhea. Most gynecologists consulted agreed that it was a common condition but spontaneously stated that the cause was often not discovered. It would seem, then, that psychic factors should always be considered in the complaint of leukorrhea.

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Nontuberculous Giant Lung Abscess Complicating Tuberculous Bronchostenosis

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A TUBERCULOUS CAVITY occupying most of or an entire pulmonary lobe is not a very rare phenomenon; neither is a nonspecific abscess of similar dimensions. However, a giant abscess occupying the entire upper lobe and developing subsequent to and beneath an adequate thoracoplasty is uncommon, especially when unaccompanied by either symptoms, signs or x-ray findings of an abscess. Such a case constitutes the subject of this report.

CASE REPORT

The patient, a 34-year-old woman, had had pulmonary tuberculosis diagnosed at the age of 18 in the course of a routine survey at school in 1937. Upon x-ray examination minimal infiltration was noted in both upper lobes. During residence of the patient in sanatoria from 1937 to 1949 no definite evidence of cavitation was found; except for the formation of a dense nodular lesion at the level of the left second anterior intercostal space, there was progressive clearing of the parenchymal lesions in both lungs as late as 1941. Left phrenic crush was performed in 1939 and an anatomically inadequate pneumothorax on the left was maintained from 1941 to 1943.

In 1942 symptoms of tuberculous tracheobronchitis were noted and sputum was found to be positive for tubercle bacilli for the first time. Repeated bronchoscopy in the course of the next few years revealed extensive tuberculous ulceration of the trachea and left bronchus which went on to healing by stenosis of the left stem bronchus. At the same time roentgenograms showed atelectasis of the left upper lobe (Figure 1, *left*). In 1948 three-stage, seven-rib left thoracoplasty was performed. Thereafter there was atelectasis of the entire lung (Figure 1, *right*) and the sputum remained positive on culture.

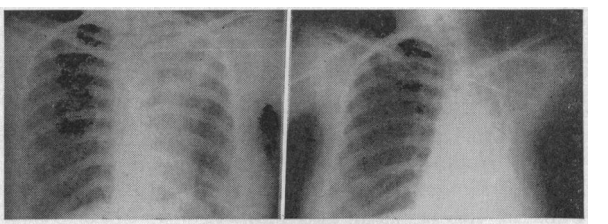

Figure 1.—*Left:* Roentgenogram (Nov. 24, 1947) showing atelectasis of the left upper lobe. *Right:* (Dec. 22, 1948) An anatomically satisfactory thoracoplasty but also atelectasis of the entire left lung.

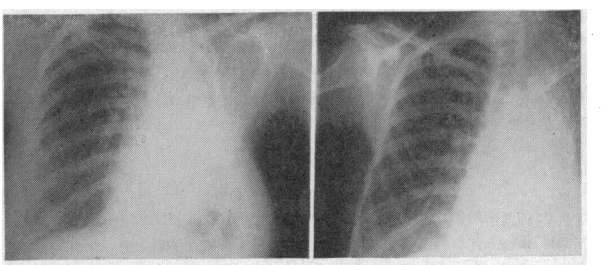

Figure 2.—Roentgenograms shortly before (*left*) and after (*right*) pneumonectomy, showing an almost identical appearance.

When the patient was first observed at the Mount Sinai Clinic in 1953, upon review of the roentgenograms no evidence was seen of tuberculous activity since the date of thoracoplasty in 1948 (Figure 2, *left*). At this time there was no growth on culture of three specimens of sputum. The patient said she had had episodes of low-grade fever, pains in the chest and increase in cough over the preceding three years without purulent sputum at any time.

A diagnosis of "destroyed" lung due to atelectasis and bronchiectasis resulting from healed broncho-

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